



General Assembly

February Session, 2012

Raised Bill No. 5284

LCO No. 1163

01163_____HS_

Referred to Committee on Human Services

Introduced by:
(HS)

***AN ACT CONCERNING RECOUPMENT OF STATE ASSISTANCE
PAYMENTS.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (a) of section 17b-137 of the general statutes is
2 repealed and the following is substituted in lieu thereof. (*Effective from*
3 *passage*):

4 (a) (1) (A) Any person who has in his possession or control any
5 property of any person applying for or presently or formerly receiving
6 aid or care or child support enforcement services, as defined in
7 subdivision (2) of subsection (b) of section 46b-231, from the state or
8 who is indebted to such applicant or recipient or has knowledge of any
9 insurance, including health insurance or property currently or
10 formerly belonging to him, or information pertaining to eligibility for
11 such aid or care or services, and any officer who has control of the
12 books and accounts of any corporation which has possession or control
13 of any property belonging to any person applying for or receiving such
14 aid or care or services or who is indebted to him, or has knowledge of
15 any insurance, including health insurance or any person having in his
16 employ any such person, shall, upon presentation by the

17 Commissioner of Social Services, or the Commissioner of
18 Administrative Services, or the Commissioner of Emergency Services
19 and Public Protection, or a support enforcement officer of the Superior
20 Court, or any person deputized by any of them, of a certificate, signed
21 by him, stating that such applicant, recipient or employee has applied
22 for or is receiving or has received such aid or care or services from the
23 state, make full disclosure to [said] such commissioner, such officer or
24 such deputy of any such property, insurance, wages, indebtedness or
25 information. Notwithstanding the provisions of this subparagraph,
26 any health insurer, including a self-insured plan, group health plan, as
27 defined in Section 607(1) of the Employee Retirement Income Security
28 Act of 1974, service benefit plan, managed care organization, health
29 care center, pharmacy benefit manager, dental benefit manager, third-
30 party administrator or other party that is, by statute, contract or
31 agreement, legally responsible for payment of a claim for a health care
32 item or service, which may or may not be financially at risk for the cost
33 of a health care item or service, shall, upon request of the
34 Commissioner of Social Services, or the commissioner's designee,
35 provide any and all information in a manner and format prescribed by
36 the commissioner, or the commissioner's designee, to identify,
37 determine or establish third-party coverage, including all information
38 necessary to determine during what period a person, his or her spouse
39 or his or her dependents may be, or may have been, covered by a
40 health insurer and the nature of the coverage that is or was provided
41 by the health insurer, including the name, address, [and] date of birth,
42 Social Security number, identifying number of the plan, plan type,
43 types of covered services, effective dates of coverage and termination
44 date for the policy holder. Such information shall be provided by such
45 health insurer to the commissioner or the commissioner's designee not
46 later than ninety days after the commissioner or the designee's initial
47 request, and not less frequently than monthly thereafter. Such
48 information shall also be provided by such health insurer to all third-
49 party administrators, pharmacy benefit managers, dental benefit
50 managers or other entities with which the health insurer has an

51 arrangement to adjudicate claims for a health care item or service.

52 (B) At the request of the Commissioner of Social Services, any health
53 insurer, including a self-insured plan, group health plan, as defined in
54 Section 607(1) of the Employee Retirement Income Security Act of
55 1974, service benefit plan, managed care organization, health care
56 center, pharmacy benefit manager, dental benefit manager, third-party
57 administrator or other party that is, by statute, contract or agreement,
58 legally responsible for payment of a claim for a health care item or
59 service, which may or may not be financially at risk for the cost of a
60 health care item or service, shall be required [, to conduct, or] to allow
61 the commissioner, or the commissioner's designee, to conduct
62 automated data matches to identify insurance coverage for recipients
63 and the parents of recipients who are minors. [Upon completion of
64 such matches the commissioner shall reimburse such companies for
65 the reasonable documented costs of conducting the matches.]

66 (2) (A) Such disclosure may be obtained in like manner of the
67 property, wages or indebtedness of any person who is either: (i) Liable
68 for the support of any such applicant or recipient, including the
69 parents of any child receiving aid or services through the Department
70 of Children and Families, or one adjudged or acknowledged to be the
71 father of an illegitimate child; or (ii) the subject of an investigation in a
72 IV-D support case, as defined in subdivision (13) of subsection (b) of
73 section 46b-231. Any company or officer who has control of the books
74 and accounts of any corporation shall make full disclosure to the IV-D
75 agency, as defined in subdivision (12) of subsection (b) of section 46b-
76 231, or to the support enforcement officer of the Superior Court of any
77 such property, wages or indebtedness in all support cases, including
78 IV-D support cases, as defined in subdivision (13) of subsection (b) of
79 section 46b-231.

80 (B) The Commissioner of Social Services, the Commissioner of
81 Administrative Services, the Commissioner of Emergency Services and
82 Public Protection or a support enforcement officer of the Superior

83 Court, or any person deputized by any of them, may compel, by
84 subpoena, the attendance and testimony under oath of any person who
85 refuses to disclose in accordance with the provisions of this section, or
86 of any person who is either: (i) Liable for the support of any such
87 applicant or recipient; or (ii) the subject of an investigation in a IV-D
88 support case, as defined in subdivision (13) of subsection (b) of section
89 46b-231, who refuses to disclose his own financial circumstances, and
90 may so compel the production of books and papers pertaining to such
91 information.

92 (C) The Commissioner of Social Services may subpoena the financial
93 records of any financial institution concerning property of any person
94 applying for or presently or formerly receiving aid or care from the
95 state or who is indebted to such applicant or recipient. The
96 Commissioner of Social Services may subpoena such records of any
97 parent or parents of any child applying for or presently or formerly
98 receiving assistance under the aid to families with dependent children
99 program, the temporary family assistance program or the state-
100 administered general assistance program.

101 (D) The commissioner, or a support enforcement officer of the
102 Superior Court, or the person deputized by the commissioner or officer
103 shall set a time and place for any examination under this subdivision,
104 and any person summoned who, without reasonable excuse, fails to
105 appear and testify or to produce such books and papers shall be fined
106 fifty dollars for each such offense.

107 Sec. 2. Section 17b-265 of the 2012 supplement to the general statutes
108 is repealed and the following is substituted in lieu thereof (*Effective*
109 *from passage*):

110 (a) In accordance with 42 USC 1396k, the Department of Social
111 Services shall be subrogated to any right of recovery or
112 indemnification that an applicant or recipient of medical assistance or
113 any legally liable relative of such applicant or recipient has against an
114 insurer or other legally liable third party including, but not limited to,

115 a self-insured plan, group health plan, as defined in Section 607(1) of
116 the Employee Retirement Income Security Act of 1974, service benefit
117 plan, managed care organization, health care center, pharmacy benefit
118 manager, dental benefit manager, third-party administrator or other
119 party that is, by statute, contract or agreement, legally responsible for
120 payment of a claim for a health care item or service, for the cost of all
121 health care items or services furnished to the applicant or recipient,
122 including, but not limited to, hospitalization, pharmaceutical services,
123 physician services, nursing services, behavioral health services, long-
124 term care services and other medical services, not to exceed the
125 amount expended by the department for such care and treatment of
126 the applicant or recipient. In the case of such a recipient who is an
127 enrollee in a care management organization under a Medicaid care
128 management contract with the state or a legally liable relative of such
129 an enrollee, the department shall be subrogated to any right of
130 recovery or indemnification which the enrollee or legally liable relative
131 has against such a private insurer or other third party for the medical
132 costs incurred by the care management organization on behalf of an
133 enrollee.

134 (b) An applicant or recipient or legally liable relative, by the act of
135 the applicant's or recipient's receiving medical assistance, shall be
136 deemed to have made a subrogation assignment and an assignment of
137 claim for benefits to the department. The department shall inform an
138 applicant of such assignments at the time of application. Any
139 entitlements from a contractual agreement with an applicant or
140 recipient, legally liable relative or a state or federal program for such
141 medical services, not to exceed the amount expended by the
142 department, shall be so assigned. Such entitlements shall be directly
143 reimbursable to the department by third party payors. The
144 Department of Social Services may assign its right to subrogation or its
145 entitlement to benefits to a designee or a health care provider
146 participating in the Medicaid program and providing services to an
147 applicant or recipient, in order to assist the provider in obtaining
148 payment for such services. In accordance with subsection (b) of section

149 38a-472, a provider that has received an assignment from the
150 department shall notify the recipient's health insurer or other legally
151 liable third party including, but not limited to, a self-insured plan,
152 group health plan, as defined in Section 607(1) of the Employee
153 Retirement Income Security Act of 1974, service benefit plan, managed
154 care organization, health care center, pharmacy benefit manager,
155 dental benefit manager, third-party administrator or other party that
156 is, by statute, contract or agreement, legally responsible for payment of
157 a claim for a health care item or service, of the assignment upon
158 rendition of services to the applicant or recipient. Failure to so notify
159 the health insurer or other legally liable third party shall render the
160 provider ineligible for payment from the department. The provider
161 shall notify the department of any request by the applicant or recipient
162 or legally liable relative or representative of such applicant or recipient
163 for billing information. This subsection shall not be construed to affect
164 the right of an applicant or recipient to maintain an independent cause
165 of action against such third party tortfeasor.

166 (c) Claims for recovery or indemnification submitted by the
167 department, or the department's designee, shall not be denied solely
168 on the basis of the date of the submission of the claim, the type or
169 format of the claim, the lack of prior authorization or the failure to
170 present proper documentation at the point-of-service that is the basis
171 of the claim, if (1) the claim is submitted by the state within the three-
172 year period beginning on the date on which the item or service was
173 furnished; and (2) any action by the state to enforce its rights with
174 respect to such claim is commenced within six years of the state's
175 submission of the claim.

176 (d) When a recipient of medical assistance has personal health
177 insurance in force covering care or other benefits provided under such
178 program, payment or part-payment of the premium for such insurance
179 may be made when deemed appropriate by the Commissioner of
180 Social Services. Effective January 1, 1992, the commissioner shall limit
181 reimbursement to medical assistance providers, except those providers

182 whose rates are established by the Commissioner of Public Health
 183 pursuant to chapter 368d, for coinsurance and deductible payments
 184 under Title XVIII of the Social Security Act to assure that the combined
 185 Medicare and Medicaid payment to the provider shall not exceed the
 186 maximum allowable under the Medicaid program fee schedules.

187 (e) Notwithstanding the provisions of subsection (c) of section 38a-
 188 553, no self-insured plan, group health plan, as defined in Section
 189 607(1) of the Employee Retirement Income Security Act of 1974, service
 190 benefit plan, managed care plan, or any plan offered or administered
 191 by a health care center, pharmacy benefit manager, dental benefit
 192 manager, third-party administrator or other party that is, by statute,
 193 contract or agreement, legally responsible for payment of a claim for a
 194 health care item or service, shall contain any provision that has the
 195 effect of denying or limiting enrollment benefits or excluding coverage
 196 because services are rendered to an insured or beneficiary who is
 197 eligible for or who received medical assistance under this chapter. No
 198 insurer, as defined in section 38a-497a, shall impose requirements on
 199 the state Medicaid agency, which has been assigned the rights of an
 200 individual eligible for Medicaid and covered for health benefits from
 201 an insurer, that differ from requirements applicable to an agent or
 202 assignee of another individual so covered.

203 (f) The Commissioner of Social Services shall not pay for any
 204 services provided under this chapter if the individual eligible for
 205 medical assistance has coverage for the services under an accident or
 206 health insurance policy.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	17b-137(a)
Sec. 2	<i>from passage</i>	17b-265

Statement of Purpose:

To clarify third-party and health plan obligations regarding payment and recoupment of state assistance payments.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]